Washington State
2007 Health Professional Loan Repayment Program

Program located at Washington State Department of Health
310 Israel Road SE ◆ PO Box 47834 ◆ Olympia, Washington 98504-7834

APPLICATION PROCESS

The Health Professional Loan Repayment Program was created by the Legislature and the governor to encourage licensed primary care health professionals to serve in shortage areas of Washington state. Awards are made on a competitive basis and limited to available funds. Financial support is provided in the form of loan repayment for a minimum three-year service obligation. Award amounts are based on loan debt with a maximum award of $25,000 per year, not to exceed $75,000. There is an opportunity to extend for a fourth and fifth year at $35,000 per year.

Priority for funding is given to sites providing service to underserved populations. The professions included are: Physicians (MD/DO/ND); Physician Assistants; Nurse Practitioners; Midwives (Certified-Nurse and Licensed); Pharmacists; Dentists; Registered Dental Hygienists; and all levels of Licensed Nurses.

Incomplete applications will not be processed. Application must include the required attachments. (See Attachment Checklist on last page.)

Applicants must be employed or have a contract to begin employment with an eligible site **PRIOR** to submitting an application. **Please see Web site for the 2007 Eligible Site List.**

There are two opportunities to apply in 2007.

Application deadlines: February 27, 2007 or July 31, 2007

If you have any questions regarding the application process please contact us at:

Web site address: www.hecb.wa.gov/health
Email: healthprof@doh.wa.gov
(360) 236-2817 or 236-2816
Fax: (360) 664-9273

Applications may be faxed **or** mailed.

2007 Health Professional Loan Repayment Program Guidelines & Terms of Agreement

Funds paid by the program to participants are for the sole purpose of repaying outstanding educational loan debt. These loans must have been secured while attending a program which led to licensure as a health professional.

ELIGIBILITY

Site Eligibility:

To be eligible, the <u>site</u> must:

- Be listed on the eligible site list that accompanies this application packet.
- Charge for professional services at the prevailing rate.
- Accept Medicaid patients using A or B of Title XVIII of the Federal Social Security Act or a state plan for medical assistance approved under Title XIX of the Act.
- Accept an assignment from Medicare under the terms specified in Title XVIII of the federal Social Security Act, section 18.42 (b)(3)(B)(ii).
- Accept patients entitled to medical assistance under the state Medicaid agency.

If the site has two or more applications from the same profession, the site will be given the opportunity to identify how the award will be distributed. A site may not receive more than one award for the same profession in the same year unless the award is split among the applicants. This award, if split among applicants, <u>will</u> <u>not</u> exceed the highest debt requested or $75,000, whichever is less.

Applicant Eligibility:

To be eligible, the <u>applicant</u> must:

- Be a United States citizen.
- Have a current and valid license to practice in Washington state.
- Be employed or have a contract to begin employment at an eligible site.
- Not owe a service obligation to the military, federal government, state, or other entity unless that obligation will be completely satisfied prior to the beginning of service under this program.
- Not be a current Health Professional Scholarship recipient.
- Have current eligible educational debt documented through loan statements.
- Not be in default on any education loans or other service obligations.

Eligible Loans:

Includes:

- Educational loans covering educational expenses.
- Loans from friends or relatives may be approved on an individual basis.

Does Not Include:

- Loans that have no current balance.
- Loans that have been consolidated under non-educational lenders (e.g. home mortgage loan).
- Stafford Parent Plus Loans.
- Loans obtained under someone else's name, such as a relative, spouse or friend.

Verification of payment on loan debt will be required periodically throughout the service obligation. Loans may not be renegotiated with lenders to accelerate repayment.

SELECTION

Applicants will be selected for participation in the Health Professional Loan Repayment Program based on the following criteria but not limited to:

- Site application score.
- Commitment and experience in serving the medically underserved or shortage areas, as described in the narrative portion of the application.

AWARD AND PAYMENTS

- The maximum award amount is $75,000, not to exceed loan debt.
- Participant must serve full-time for a minimum of three years. Full-time is considered a minimum of 40 hours per week. The service obligation will be prorated for less than 40 hours per week.
- Awards will be divided into quarterly payments over the obligation period.
- Credit is earned during the quarter and payments are made after the completion of each quarter upon receipt, review and approval of the Service Verification Form.
- Participants agree to allow the program access to loan records and to acquire information from lenders necessary to verify eligibility and to determine payments.
- All program funds must be applied to the approved lender(s) listed on Award Notification.

- For program audit requirements, payment history tracking begins the month the first check is issued - not the first day of the contract period.
- Funds can not be used to repay yourself or anyone else for payments made prior to the issue of the first check.

REPAYMENT

Participants who do not fulfill the terms of the contract will be considered in default and will owe a double penalty.

- Participants who serve less than the service obligation period specified in their Award Notification must repay the program an amount equal to twice the total amount paid by the program.
- Funds not applied to the educational lenders, as identified in the Award Notification, shall be repaid to the program.
- The program may waive, in full or in part, the obligation for service or its rights to recover financial damages if the program determines that failure to fulfill the service obligation was due to circumstances beyond the participant's control such as:
  - Physical impairment or mental impairment to the degree that the participant can no longer function in his/her assigned duties, or
  - The participant's death.
- The program shall not be held responsible for any outstanding payments on principal and interest to any lender.

It is your responsibility to read and understand these Guidelines and Terms of Agreement.

If you have questions please contact our office:

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Washington State
2007 Health Professional Loan Repayment Program Application

"Benefit from being needed"

Personal

1. Name: _____ _____ _____ **2**. SS #: ____/____/____
Last Name *First Name* *MI*

3. Address: _____City:_____ State:_____ Zip:_____

4. Date of Birth: ____/____/____ **5**. E-mail Address: _____

6. Telephone: Home: (____)_____ Work: (____)_____ **7**. ○ Male ○ Female

8. Career Needs of Spouse (if applicable): _____

9. Your Hometown: _____ **10**. Spouse's Hometown: _____

11. Your Ethnic Origin *(Optional)*: _____ **12**. U.S. Citizen: ○Yes ○ No *(must be U.S citizen to apply)*

13. Do you have another service obligation? **Please note: program recipients cannot commit simultaneously to two service obligations.** ○ Yes ○ No (If yes, please specify below.)

○ Health Professional Scholarship ○National Health Service Corp ○ Indian Health Service ○Military

○ Other (Specify): _____ Dates of obligation:_____ to _____

14. Are you in default on any educational loans? ○ Yes ○ No *If yes, explain:*_____

15. List all educational lender names and current loan balances for which you are requesting loan repayment:
(Be sure to include all lenders at this time, you will not be able to add them at a later date.)

Lender 1: _____ Balance: $_____

Lender 2: _____ Balance: $_____

Lender 3: _____ Balance: $_____

Lender 4: _____ Balance: $_____

Total Educational Debt: $_____

(Use additional sheet if needed. **Include copies of current loan statements with application**.)

Education

1. Undergraduate School: _____ GPA: _____

Degree: _____ Date Received: _____ Years/Credits Completed: _____

2. Graduate/Professional School: _____ GPA:_____

Degree: _____Date Received: _____ Years/Credits Completed: _____

3. Date and Place of : a. Residency:_____ _____
Place Dates

b. Internship: _____ _____
Place Dates

c. Preceptorship: _____ _____
Place Dates

Current and Professional Status

1. Provider Type: _____

2. Current Status: ○ In Practice ○In Residency ○ Military ○ Other (describe): _____

3. Are you Board eligible? ○Yes ○No **4.** Board certified? ○Yes ○No Specialty:_____

Employment Information

Facility must be on current approved Site List to be eligible to apply.

1. Facility Name: _____

2. Address: _____

City: _____ State: _____ Zip: _____

3. County: _____ **4.** Name of Contact Person: _____

5. Contact's Telephone: (_____) _____ **6.** FAX: (_____) _____

7. Employment Begin Date: _____ **8.** Work E-mail: _____
(We use email on a regular basis to communicate with participants)

9. ○ Work Part-time ○ Work Full-time Days Per Week: _____ Hours Per Week: _____

For this program, full time is considered to be a minimum of 40 hours per week. If less than 40 hours per week, your service obligation will be prorated accordingly. (Example: 32 hours per week would require a service obligation of 3 years and 9 months.)

Licensure Information

1. Are you a licensed health care provider in Washington State? ○ Yes ○ No

If "Yes," provide the license number: _____

If "No," estimated date to obtain license: _____

2. Are you a licensed health care provider in any state other than Washington? ○ Yes ○ No

If "Yes," what type of license:_____State: _____

Professional Experience

(Make brief, concise statements)

1. Summarize your work, training, and practice experience.

2. Comment specifically on your experiences in rural/underserved urban areas.

Professional Experience (continued)

3. Describe your long-range personal and professional goals.

4. Discuss your commitment to serve in this community/site.

5. Describe any life experiences you believe make you an appropriate match for this community/site. Include such things as multicultural experiences, languages in which you are fluent, hobbies, interests, etc.

Agreement

I certify that the statements made herein are correct to the best of my knowledge. I have read and agree to the 2007 Health Professional Loan Repayment Program Guidelines and Terms of Agreement. I authorize the Health Professional Loan Repayment Program to maintain a record of this information. I understand that any referral by the Health Professional Loan Repayment Program to the attached eligible site list is not to be interpreted as an endorsement by the program. I further understand that it is my responsibility to evaluate the credentials and references of the site/opportunities/providers.

I agree, if accepted into this program, to serve for a minimum of three years and to accept Medicare assignments and Medicaid patients. I further agree that all funds obtained from this program will be applied to the approved educational lenders submitted with this application and to be identified as approved in the Award Notification.

_____	_____	_____
Signature of Applicant	***Printed Name***	***Date***

Attachment Checklist

(Please include all attachments <u>with</u> the application packet.)

- ☐ **<u>Current</u>** loan statement(s) with <u>outstanding</u> educational debt amount **(required)**

  Be sure to include <u>all</u> eligible debt. Once the award is made you will not be able to add lenders to your list.

- ☐ Three letters of recommendation from training supervisors/professional colleagues **(required)**
- ☐ Facility Administrator Confirmation Form **(required)**
- ☐ Letter confirming residency certification *(if applicable)*
- ☐ Verification of Board eligibility *(if applicable)*
- ☐ Copy (photo copy acceptable) of professional school transcript (**required)**
- ☐ Copy of employer/employee contract and/or agreement ***(required).*** *If no contract or agreement exists, submit a signed/dated letter from your supervisor on company letterhead verifying the date you were employed, your position, and the number of hours you work each week.*

Mail Completed Application and Required Attachments to:

Health Professional Loan Repayment Program
Office of Community and Rural Health
310 Israel Road SW
P.O. Box 47834
Olympia, WA 98504-7834
Fax: (360) 664-9273

<u>Deadlines for 2007 Applications</u>

Applications must be postmarked no later than:
First Cycle: February 27, 2007 Second Cycle: July 31, 2007

2007 Facility Administrator Confirmation Form

*This form is to be completed by facility administrator/medical director or appropriate designee and **must** accompany completed application packet.*

Applicant: _____ _____
First Name *Last Name*

Applicant Work Site Name: _____

_____
Address *City* *Zip*

FTE Status: _____ **Hours per week:** _____

A. Discuss the importance and role of this applicant in your facility/site.

B. Describe the impact of the loan repayment benefit to recruit or retain this applicant.

C. Has your site received funds from other state or federal programs, (e.g.; National Health Service Corp, Rural Health Outreach Grant, Health Systems Resource Grant)?

○ Yes ○ No If yes, please describe: _____

I certify that this Loan Repayment program applicant meets all the qualifications for which the site received access barrier points in the site application process. The applicant has made a commitment to stay at this facility for a minimum of three years while participating in the Loan Repayment Program.

Administrator Name: _____ Title: _____
(Print or type)

Signature: _____ Date: _____

Administrative Site Name: _____

Address: _____
Street *City* *State* *Zip*

Phone: _____ Fax : _____